Filing at a Glance

Company: Federated Mutual Insurance Company

Product Name: Group Short-Term Disabiliy	SERFF Tr Num: FEMC-127624086	State: Arkansas
TOI: H11G Group Health - Disability Income	SERFF Status: Closed-Disapproved	State Tr Num: 49792
Sub-TOI: H11G.002 Short Term	Co Tr Num:	State Status: Waiting Industry Response
Filing Type: Form		Reviewer(s): Donna Lambert
	Author: Jeanette Myers	Disposition Date: 10/14/2011
	Date Submitted: 09/14/2011	Disposition Status: Disapproved
Implementation Date Requested: 01/01/2011		Implementation Date: 11/14/2011

State Filing Description:

General Information

Project Name: DIPolicy2012	Status of Filing in Domicile: Pending
Project Number: DIPolicy2012	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 10/14/2011	
State Status Changed: 09/28/2011	Deemer Date:
Created By: Jeanette Myers	Submitted By: Jeanette Myers
Corresponding Filing Tracking Number:	

Filing Description:

Federated Mutual Insurance Company is submitting a group short term disability policy and group short term disability certificate for your review and approval. The submitted forms are new forms. The policies will be issued to employers of small and large group markets

The group short term disability policy and group short term disability certificate are identical except for the first page, therefore we are only submitting one set of the policy and certificate sections (Section I through Section 7) and two face pages with indexes.

While attached forms are submitted on 8 ½ by 11 paper, we may also print the same text in a booklet format (e.g. 5 ½

by 8 ½) or on electronic media (e.g. CD-ROM, Internet), if requested by the policyholder. The type font may change but the font-size will remain at least 10pt. We may also issue certificates in a foreign language, based upon a direct translation of the filed wording.

Company and Contact

Filing Contact Information

Jeanette Myers, Compliance Analyst	jmmyers@fedins.com
121 East Park Square	800-533-0472 [Phone]
Owatonna, MN 55060	507-455-8226 [FAX]

Filing Company Information

Federated Mutual Insurance Company	CoCode: 13935	State of Domicile: Minnesota
121 East Park Square	Group Code: 7	Company Type:
PO Box 328	Group Name:	State ID Number:
Owatonna, MN 55060	FEIN Number: 41-0417460	
(800) 533-0472 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$500.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federated Mutual Insurance Company	$500.00	09/14/2011	51592703

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Donna Lambert	10/14/2011	10/14/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Donna Lambert	09/28/2011	09/28/2011	Jeanette Myers	10/13/2011	10/13/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	General Provisions	Jeanette Myers	09/15/2011	09/15/2011
Form	Enrollment and Effective Date	Jeanette Myers	09/15/2011	09/15/2011
Form	Termination of Coverage	Jeanette Myers	09/15/2011	09/15/2011
Form	Covered Events	Jeanette Myers	09/15/2011	09/15/2011
Form	Exclusions	Jeanette Myers	09/15/2011	09/15/2011
Form	Definitions	Jeanette Myers	09/15/2011	09/15/2011

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
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TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Disposition

Disposition Date: 10/14/2011
Implementation Date: 11/14/2011
Status: Disapproved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	No
Supporting Document	Application	Approved	No
Form *(revised)*	Cover Page	Approved	No
Form	Cover Page	Disapproved	No
Form *(revised)*	Cover Page	Approved	No
Form	Cover Page	Disapproved	No
Form *(revised)*	General Provisions	Approved	No
Form	General Provisions	Disapproved	No
Form	General Provisions	Disapproved	No
Form *(revised)*	Enrollment and Effective Date	Approved	No
Form	Enrollment and Effective Date	Disapproved	No
Form *(revised)*	Termination of Coverage	Approved	No
Form	Termination of Coverage	Disapproved	No
Form *(revised)*	Covered Events	Approved	No
Form	Covered Events	Disapproved	No
Form *(revised)*	Exclusions	Approved	No
Form	Exclusions	Disapproved	No
Form	Exclusions	Disapproved	No
Form *(revised)*	Definitions	Approved	No
Form	Definitions	Disapproved	No
Form *(revised)*	Grievance and Appeals Procedures	Approved	No
Form	Grievance and Appeals Procedures	Disapproved	No
Form	Schedule of Benefits	Approved	No

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/28/2011
Submitted Date	09/28/2011
Respond By Date	

Dear Jeanette Myers,

This will acknowledge receipt of the captioned filing.

Objection 1

- General Provisions, GI 00 01 (01-12 ed.) (Form)

Comment: This filing has been reviewed, and the following revisions are necessary.

ACA 23-86-106 defines eligible groups. No product can be marketed to an association unless the requirements of 23-86-106(2) are met. Please give us your assurance that no product will be marketed to any association unless the association is first filed with and approved by the Department. In the future, if a product is filed for issuance to associations and employer groups, please add "associations" to Group Market Type in the General Information section of the filing.

Officer's signatures must be displayed. They may be variable and contained in brackets, allowing the names and titles to be changed as necessary without a new filing. See 23-79-116

A provision that new members may be added to the group is required by 23-86-108.

Certificates

Certificates must always be provided to the covered employees, not just at the company's option, as required by 23-86-108(2)(B). Please correct this provision.

Subrogation

The coverage must provide a minimum benefit of $50 per month. Please see 23-86-111(b)(1).

Incorrect Premium Payment

Remove the last sentence. All overpayments must be refunded.

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Objection 2

- Grievance and Appeals Procedures, GI 00 07 (01-12 ed.) (Form)

Comment: Arkansas requires, in 23-79-138, that certain policy information be provided. In the first paragraph of Section 1, replace "insurance regulator in their state to submit a grievance or complaint," with "the Arkansas Insurance Department." Replace all instances of "your state insurance regulatory agency," with "the Arkansas Insurance Department". Please bring this form into compliance.

Objection 3

- Exclusions, GI 00 05 (01-12 ed.) (Form)

Comment: Your exclusions of "insurrection, rebellion, armed invasion or aggression" appear to be other ways to define terrorism. Our Department will not approve exclusions for terrorism or other similar language in life or accident and health contracts. Please remove these exclusions.

Objection 4

- Cover Page, GI 03 11 (01-12 ed.) (Form)

Comment: See policy objection regarding officers' signatures.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Donna Lambert

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/13/2011
Submitted Date	10/13/2011

Dear Donna Lambert,

Comments:
Please see our responses below.

Response 1

Comments: You have Federated Mutual Insurance Company's assurance that no product will be marketed to any association unless the association is first filed with and approved by the Arkansas Department of Insurance.

The provisions regarding adding new members are found in form GI 00 02 (01-12 ed.), Enrollment and Effective Date.

Form GI 00 01 (01-12 ed.), item 16 has been amended. Also the form number has been changed to GI 03 01 (01-12 ed.)

The minimum amount of coverage provided by this policy is $100 per week. The bracketed amounts on the Schedule of Benefits, GI 00 20 (01-12 ed.) are the minimum to maximum amounts offered.

Form GI 03 01 (01-12 ed.), item 19.e. has been amended.

Related Objection 1

Applies To:

- General Provisions, GI 00 01 (01-12 ed.) (Form)

Comment:
This filing has been reviewed, and the following revisions are necessary.

ACA 23-86-106 defines eligible groups. No product can be marketed to an association unless the requirements of 23-86-106(2) are met. Please give us your assurance that no product will be marketed to any association unless the association is first filed with and approved by the Department. In the future, if a product is filed for issuance to associations and employer groups, please add "associations" to Group Market Type in the General Information section of the filing.

Officer's signatures must be displayed. They may be variable and contained in brackets, allowing the names and titles to be changed as necessary without a new filing. See 23-79-116

A provision that new members may be added to the group is required by 23-86-108.

Certificates
Certificates must always be provided to the covered employees, not just at the company's option, as required by 23-86-108(2)(B). Please correct this provision.

Subrogation
The coverage must provide a minimum benefit of $50 per month. Please see 23-86-111(b)(1).

Incorrect Premium Payment
Remove the last sentence. All overpayments must be refunded.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
General Provisions	GI 03 01 (01-12 ed.)		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial			GI 03 01 _01-12 ed._.pdf
Previous Version							
General Provisions	*GI 00 01 (01-12 ed.)*		*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*			GI 00 01 _01-12 ed._.pdf
General Provisions	*GI 00 01 (01-12 ed.)*		*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement*	*Initial*			GI 00 01 _01-12 ed._.pdf

or Rider

No Rate/Rule Schedule items changed.

Response 2

Comments: Form GI 00 07 (01-12 ed.) has been amended and the form number has been changed to GI 03 07 (01-12 ed.).

Related Objection 1

Applies To:

- Grievance and Appeals Procedures, GI 00 07 (01-12 ed.) (Form)

Comment:

Arkansas requires, in 23-79-138, that certain policy information be provided. In the first paragraph of Section 1, replace "insurance regulator in their state to submit a grievance or complaint," with "the Arkansas Insurance Department." Replace all instances of "your state insurance regulatory agency," with "the Arkansas Insurance Department". Please bring this form into compliance.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Grievance and Appeals Procedures	GI 03 07 (01-12 ed.)		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial			GI 03 07 _01-12 ed._.pdf
Previous Version							
Grievance and Appeals Procedures	*GI 00 07 (01-12 ed.)*		*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*			GI 00 07 _01-12 ed._.pdf

No Rate/Rule Schedule items changed.

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Response 3

Comments: Form GI 00 05 (01-12 ed.), item 11 has been amended and the form number has been changed to GI 03 05 (01-12 ed.).

Related Objection 1

Applies To:

- Exclusions, GI 00 05 (01-12 ed.) (Form)

Comment:

Your exclusions of "insurrection, rebellion, armed invasion or aggression" appear to be other ways to define terrorism. Our Department will not approve exclusions for terrorism or other similar language in life or accident and health contracts. Please remove these exclusions.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Exclusions	GI 03 05 (01-12 ed.)		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial			GI 03 05 _01-12 ed._.pdf
Previous Version							
Exclusions	*GI 00 05 (01-12 ed.)*		*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*			GI 00 05 _01-12 ed._.pdf
Exclusions	*GI 00 05 (01-12 ed.)*		*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*			GI 00 05 _01-12 ed._.pdf

No Rate/Rule Schedule items changed.

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Response 4

Comments: The officer’s signatures have been added and bracketed.

Related Objection 1

Applies To:

- Cover Page, GI 03 11 (01-12 ed.) (Form)

Comment:

See policy objection regarding officers' signatures.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Cover Page	GI 03 10 (01-12 ed.)		Policy/Contract/Fraternal Certificate	Initial			GI 03 10 _01-12 ed._.pdf
Previous Version							
Cover Page	*GI 03 10 (01-12 ed.)*		*Policy/Contract/Fraternal Certificate*	*Initial*			GI 03 10 _01-12 ed._.pdf
Cover Page	GI 03 11 (01-12 ed.)		Certificate	Initial			GI 03 11 _01-12 ed._.pdf
Previous Version							
Cover Page	*GI 03 11 (01-12 ed.)*		*Certificate*	*Initial*			GI 03 11 _01-12 ed._.pdf

No Rate/Rule Schedule items changed.

We respectfully request your further review of this filing for approval.

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Sincerely,

Jeanette Myers

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Amendment Letter

Submitted Date: 09/15/2011

Comments:

After submission we noticed that some of the forms contained typos in the form numbersn. These have been corrected in this amendment.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
GI 00 01 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	General Provisions	Initial					GI 00 01 _01-12 ed._.pdf
GI 00 02 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Enrollment and Effective Date	Initial					GI 00 02 _01-12 ed._.pdf
GI 00 03 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Termination of Coverage	Initial					GI 00 03 _01-12 ed._.pdf
GI 00 04	Policy/Contr	Covered	Initial					GI 00 04 _01-

(01-12 ed.)	act/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Events			12 ed._.pdf
GI 00 05 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Exclusions	Initial		GI 00 05 _01-12 ed._.pdf
GI 00 06 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Definitions	Initial		GI 00 06 _01-12 ed._.pdf

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Form Schedule

Lead Form Number: GI 03 10 (01-12 ed.)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/14/2011	GI 03 10 (01-12 ed.)	Policy/Contract/Fraternal Certificate	Cover Page	Initial			GI 03 10 _01-12 ed._.pdf
Approved 10/14/2011	GI 03 11 (01-12 ed.)	Certificate	Cover Page	Initial			GI 03 11 _01-12 ed._.pdf
Approved 10/14/2011	GI 03 01 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	General Provisions	Initial			GI 03 01 _01-12 ed._.pdf
Approved 10/14/2011	GI 00 02 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Enrollment and Effective Date	Initial			GI 00 02 _01-12 ed._.pdf
Approved 10/14/2011	GI 00 03 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page,	Termination of Coverage	Initial			GI 00 03 _01-12 ed._.pdf

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*		
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*		
Company Tracking Number:					
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*		
Product Name:	*Group Short-Term Disabiliy*				
Project Name/Number:	*DIPolicy2012/DIPolicy2012*				

		Endorsement or Rider				
Approved 10/14/2011	GI 00 04 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Covered Events	Initial		GI 00 04 _01-12 ed._.pdf
Approved 10/14/2011	GI 03 05 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Exclusions	Initial		GI 03 05 _01-12 ed._.pdf
Approved 10/14/2011	GI 00 06 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Definitions	Initial		GI 00 06 _01-12 ed._.pdf
Approved 10/14/2011	GI 03 07 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Grievance and Appeals Procedures	Initial		GI 03 07 _01-12 ed._.pdf

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Approved 10/14/2011	GI 00 20 (01-12 ed.)	Schedule Pages	Schedule of Benefits	Initial	GI 00 20 01-12 ed.pdf

FEDERATED MUTUAL

INSURANCE COMPANY
HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060
Phone: 800-533-0472

GROUP DISABILITY INCOME POLICY

Policyholder: _____

_____

_____

Policy Effective Date: _____
at 12:01 a.m. Central Standard Time

Policy Anniversary: _____ and annually each year thereafter.

Policy Number: _____

This policy is delivered in Arkansas and is governed by its laws.

CONSIDERATION. The **policy** is issued to the **policyholder** in consideration of the application and payment of premiums.

MEMBER OF THE COMPANY. By virtue of this **policy**, the **policyholder** is a member of Federated Mutual Insurance Company. **Our** annual meetings are held at the Home Office on the third Tuesday in April at 10:00 A.M.

SECRETARY

PRESIDENT

INDEX

FEDERATED MUTUAL

INSURANCE COMPANY

121 East Park Square ▪ Owatonna, MN 55060

GROUP DISABILITY INCOME CERTIFICATE OF COVERAGE

Employee:
IDN:
Coverage:
Effective Date:
Employer:
Group No.:

POLICY NUMBER:
POLICYHOLDER:

The **policy** is delivered in Arkansas and is governed by its laws.

The insurance is effective on the date shown above, provided the **employee** meets the eligibility requirements of the **policy**.

The principal provisions of the **policy** are set forth in the following pages. This certificate is not the policy. It replaces any other certificate previously issued to the **employee** under the above **policy** number. The terms and conditions of the **policy** control the coverage provided.

Words and phrases appearing in bold type throughout the certificate have special meaning as set forth in the Definitions (form GI 00 06).

Executed by Federated Mutual Insurance Company at Owatonna, Minnesota.

SECRETARY

PRESIDENT

INDEX

SECTION I - GENERAL PROVISIONS

Various provisions in this document restrict coverage. Read the entire document carefully to determine rights, duties and what is and is not covered.

The words "**we**", "**us**" and "**our**" refer to Federated Mutual Insurance Company.

The word "**policyholder**" means the organization or employer listed as such on the face page.

Other words and phrases appearing in **bold** type have special meaning. Refer to Section VI - Definitions.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

1. **BENEFITS**

   We agree to pay **benefits** as provided in the **policy** to **covered employees**.

2. **POLICY** CHANGES

   Changes may be made in the **policy** only by **us** acting through **our** President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the **policy**.

3. ENTIRE CONTRACT

   The entire contract will be made up of the **policy**, the application of the **policyholder**, the applications of the **employers** and the applications of **covered employees**. All references to statements, applications, writings, and signatures as they apply to the terms of the **policy** will include their representations in electronic form, as agreed to by both **us** and the **covered person**, **employer**, or **policyholder** who made the statement, application, writing or signature.

4. INSURANCE DATA

   The **employer** will give **us** all of the data that **we** need to calculate the premium and all other information that **we** may reasonably require. **We** have the right to examine the **employer's** records relative to the **policy** at any reasonable time while the **policy** is in effect. **We** also have this right until all rights and obligations under the **policy** are finally determined.

5. STATEMENTS NOT WARRANTIES

   All statements made by the **policyholder** or **employer** or **covered employee** will, in the absence of fraud, be deemed representations and not warranties. No statement made by the **policyholder** or **employer** or **covered employee** to obtain coverage will be used to avoid or reduce the coverage unless it is made in writing and is signed by the policyholder or employer or **covered employee** and a copy is sent to the **policyholder** or **employer** or **covered employee** or his **beneficiary**.

6. MISSTATEMENT

   If information in the application of a **covered employee** has been misstated, the corrected age will be used to determine whether insurance is in force under the **policy** and in what amount. If insurance remains in force an equitable adjustment of premium may be made.

7. RIGHT TO CONTEST

   We have no right to contest the coverage of an **employer** on the basis of any statement made in the **employer's** application after the **employer's** coverage has been in force for two years. Before then **we** have the right to contest only if the statement was in writing on a form signed by the **employer** and a copy of it is given to the **employer.** Coverage will only be rescinded for fraud or intentional misrepresentation of a material fact made by the **employer** in his application. Nothing in this provision shall keep **us** from using at any time a defense based on **policy** provisions that relate to eligibility for coverage.

   We have no right to contest the coverage of a covered employee on the basis of any statement made in a **covered employee's** application after the **covered employee's** coverage has been in force for two years. Before then **we** have the right to contest only if the statement was in writing on a form signed by the **covered employee** and a copy of it is given to the **covered employee** or his **beneficiary**. Coverage will only be rescinded for fraud or intentional misrepresentation of a material fact made by the **covered person** in his application. Nothing in this provision shall keep us from using at any time a defense based on **policy** provisions that relate to eligibility for coverage.

8. NOTICE OF CLAIM

Written notice of claim must be given to **us** within 30 days after the occurrence or commencement of any loss covered by the **policy**, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the **covered employee** to **us** at 121 East Park Square, Owatonna, Minnesota 55060, or to any of **our** authorized agents, with information sufficient to identify the **covered employee**, shall be deemed notice to **us**.

9. CLAIM FORMS

Upon receipt of a notice of claim, **we** will furnish to the **covered employee** forms for filing proof of loss. If such forms are not furnished within 15 days after we receive the notice of claim, the **covered employee** shall be deemed to have complied with the requirements of the **policy** regarding proof of loss, if within 90 days the **covered employee** gives **us** written proof covering the occurrence, the character and the extent of the loss for which claim is made.

10. PROOF OF LOSS

Written proof of loss must be furnished to us within 90 days after the date of loss. Failure to furnish such proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, shall the proof of loss be submitted more than one year from the time proof is otherwise required.

11. TO WHOM PAYABLE

All **benefits** are payable to the **covered employee**.

If any **employee** to whom **benefits** are payable is a minor or, in **our** opinion, is not able to give valid receipt for any payment due him, such payment will be made to his legal guardian.

If a **covered employee** dies while **benefits** remain unpaid, **we** may choose to make direct payment to the **covered employee's beneficiary**.

Payment in the manner described above will release **us** from all liability to the extent of any payment made.

12. TIMING OF BENEFIT PAYMENTS

Initial **benefits** for **disability** are payable within 30 **calendar days** of the date **we** receive a clean claim. If additional information is needed to process a claim, a request will be sent to the **provider** or **covered employee** within 30 **calendar days**. Additional **benefits** for **disability** will be paid every 14 days.

A "clean claim" is one where no additional documentation or information is needed to determine eligibility or process the claim. "Clean claim" does not include claims for **disability** during times when premium is not paid or where fraud is suspected.

13. PHYSICAL EXAMINATIONS AND AUTOPSY

We, at **our** expense, shall have the right and opportunity to examine the **covered employee** when and as often as **we** may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

14. LEGAL ACTIONS

No action at law or in equity will be brought to recover on the **policy** until at least 60 days after completion of all appeals as outlined in Section VII - **Grievance** and Appeal Procedure. No action will be brought at all unless brought within 3 years after the time within which the appeals are complete.

15. **PHYSICIAN** / PATIENT RELATIONSHIP

The **covered employee** will have the right to choose any **physician** who is practicing legally. **We** will in no way disturb the **physician** / patient relationship.

16. CERTIFICATES

We will issue to the **employer** for delivery to each **covered employee** an individual certificate or **we** will deliver to each **covered employee** an individual certificate. The certificate will show the **benefits** provided under the **policy** and to whom **benefits** will be paid. Nothing in the certificate will change or void the terms of the **policy**.

17. SEVERABILITY

Any provision of the **policy** that is prohibited by law shall be void and be without force or effect. But this will not invalidate the enforceability of any other term, condition or provision of the **policy**.

18. SUBROGATION

To the extent allowed by law, when **we** have provided **benefits** to or on behalf of a **covered employee** due to **disability**, **we** will have subrogation and/or reimbursement rights. If a **covered employee** recovers damages from a third party who is liable for the **disability**, the **covered employee** will reimburse us for amounts **we** have paid as **benefits** for that **disability**. If a **covered employee** recovers damages for the **disability** from any other insurance, the **covered employee** will reimburse **us** for amounts **we** have paid as **benefits** for that **disability**.

The **covered employee** will not prejudice **our** right to recover from a liable third party. Entering into a settlement or compromise arrangement without **our** prior consent will be deemed to prejudice **our** rights. A **covered employee** must notify us anytime he has a claim against a third party for **disability** for which **we** have paid **benefits**.

This subrogation provision will apply to any settlement or judgement received by the **covered employee**. **We** are entitled to full recovery of **benefits we** paid even if:

a. The third party does not admit liability; or

b. The settlement or judgment does not identify any amounts paid as income loss.

We are not required to participate in any legal action by the **covered employee** to recover damages. **We** are not required to pay any fees or costs incurred by the **covered employee** or his attorney to recover damage

19. PREMIUMS

a. PREMIUM PAYMENT. The premium for each **covered employee** will be due prior to the first day of each **month**. All premiums are payable in advance by the **employer** at **our** Home Office or to **our** designated premium collection agent. All premiums must be made payable to 'Federated Mutual Insurance Company". **Our** insurance agents are not authorized to collect premiums other than the first premium.

b. MONTHLY PREMIUM STATEMENT. A monthly premium statement will be prepared prior to the premium due date. This monthly premium statement will show the premium due and will reflect any pro rata premium charges and credits due to changes in the number of **covered employees** and changes in coverage that took place in the preceding **month**.

c. CHANGES IN PREMIUM RATES. **We** may change any premium rate from time to time with at least 31 days advance written notice. No change in rates will be made until 12 **months** after the date an **employer** purchases in the **policy**.

However, **we** may change rates immediately only if, in **our** opinion, **our** liability is altered:

i. by any change in state or federal law; or

ii. by a revision in the insurance under the **policy** including but not limited to changes of over 20% in the number of **covered employees** with any one **employer**.

Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

If an increase in rates takes place on a date that is not a premium due date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next premium due date. If a decrease in rates takes place on a date that is not a premium due date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next premium due date.

d. GRACE PERIOD. If, before a premium due date, the **employer** has not given written notice to us that the coverage for the **employer** is to terminate, a grace period of 31 days will be granted for the payment of each premium after the first premium. The coverage will stay in force during that time. If **we** do not receive the premium payment by the end of the grace period, the coverage will automatically terminate at the end of the grace period. However, if the **employer** has given written notice in advance of an earlier date of termination, the insurance will terminate as of the earlier date. The **employer** will be liable to us for any unpaid premium for the time the coverage was in force including the grace period.

e. INCORRECT PREMIUM PAYMENT. Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has terminated, will be refunded without interest when requested by the **employer**.

f. NON-PARTICIPATING PREMIUM REFUNDS. The **policy** does not share in **our** surplus earnings.

SECTION II - ENROLLMENT & EFFECTIVE DATE

Words and phrases appearing in bold type have special meaning as set forth in Section VI - Definitions.

1. **EMPLOYER** ENROLLMENT

   An **employer** shall apply to become a covered **employer** or **policyholder**. The **employer** will become a covered **employer** or **policyholder** on the first day of the month coinciding with or following the date such **employer** applies subject to:

   a. Approval by **us**; and

   b. Meeting the participation requirements shown below; and

   c. Meeting the contribution requirements shown below.

2. PARTICIPATION REQUIREMENTS

   a. When the **employer** pays the entire premium for each **covered employee**, 100% of the eligible **employees** not covered under a separate unrelated employer's plan must be enrolled for coverage at all times.

   b. When **covered employees** contribute to the premium payment, a minimum of 85% of all eligible **employees** not covered under a separate unrelated employer's plan must be enrolled at all times.

   c. In addition, a minimum of two (2) eligible **employees** must always be insured under each **employer's** plan in order for coverage to be issued or continued.

3. CONTRIBUTION REQUIREMENTS

   When an **employer** does not pay the full premium for **covered employees**, the **employer** must pay a minimum of 70% of the premium for **covered employees**.

4. **EMPLOYEE** ELIGIBILITY

   a. An **employee** is eligible for coverage under the **policy** if he:

      i. is under age 70; and

      ii. is **actively at work;** and:

      iii. has completed the **waiting period** shown in the **employer's** application for coverage or was covered under the **employer's** prior plan on the day before the effective date of the **employer's** coverage with **us**; and

      iv. has submitted **proof of good health**.

   b. Once enrolled, an **employee** is eligible for coverage under the **policy** only if he is **actively at work**.

5. **EMPLOYEE** EFFECTIVE DATE

   a. Each eligible **employee** may elect coverage by completing and signing an application. The effective date of his coverage depends upon the date on which the **employee** elects the coverage.

      i. If elected on or before the date he becomes eligible, his coverage will be effective on the first day of the **month** after he becomes eligible.

      ii. If elected within 31 days after he becomes eligible, his coverage will be effective on the first day of the **month** after election.

      iii. If elected more than 31 days after he becomes eligible, his coverage will be effective on the first day of the **month** after **we** approve his application for coverage.

      iv. If his coverage ceased because he cancelled his payroll deduction, and he again elects to be insured, his coverage will be effective on the first day of the **month** after **we** approve his application for coverage.

   b. The **employee** must be **actively at work** on the effective date of his coverage for coverage to take effect.

   c. The **employee** must be **actively at work** on the effective date of any change in his coverage for such change in coverage to take effect.

SECTION III - TERMINATION OF COVERAGE

Words and phrases appearing in **bold** type have special meaning as set forth in Section VI - Definitions.

1. The **employer's** coverage under the **policy** will terminate at the earliest of the following dates:
   a. the date the **employer** fails to make any premium payment when due;
   b. the date the **employer** fails to comply with the **employer** contribution rules;
   c. the date participation requirements are no longer met;
   d. the date the **employer** commits fraud or intentionally misrepresents a material fact;
   e. for association groups, the date the membership of an **employer** in the association ceases; or
   f. the date we elect to discontinue the **policy** as permitted by state and federal law.
2. An **employee's** coverage will terminate on the earliest of the following dates:
   a. the date the **employer's** coverage terminates;
   b. the date the **employee** is not eligible for coverage;
   c. the date the **employee** does not make required premium contributions;
   d. the date the **policy** terminates;
   e. the date the **employee** reaches age 70.
3. The **employer** has the right to terminate coverage by providing **us** with advance written notice of his intent. The notice must be sent to **us** at the following address.

   Group Administration
   Federated Mutual Insurance Company
   PO Box 328
   Owatonna, MN 55060

   Coverage will terminate on the last day of the **month** in which **we** receive the **employer's** written notice of intent to terminate.
4. An **employee** has the right to terminate coverage by providing his **employer** with advance written notice of his intent. The **employer** must then notify **us** at the following address.

   Group Administration
   Federated Mutual Insurance Company
   PO Box 328
   Owatonna, MN 55060

   or by calling 800-377-9154.

   An **employee's** coverage will terminate on the last day of the **month** in which **we** receive the **employer's** notice of intent to terminate coverage for that **employee**.
5. GRACE PERIOD

   If, before a premium due date, the **employer** has not given written notice to **us** that the coverage for the **employer** is to terminate, a grace period of 31 days will be granted for the payment of each premium after the first premium. The coverage will stay in force during that time. If **we** do not receive the premium payment by the end of the grace period, the coverage will automatically terminate at the end of the grace period. However, if the **employer** has given written notice in advance of an earlier date of termination, the insurance will terminate as of the earlier date. The **employer** will be liable to **us** for any unpaid premium for the time the coverage was in force including the grace period.

SECTION IV - **COVERED EVENTS**

Words and phrases appearing in **bold** type have special meaning as set forth in Section VI - Definitions.

1. If a **covered event** happens to a **covered person**, **we** will pay benefits as provided in the **schedule**. Payment of **benefits** will be subject to provisions set forth in the **schedule**. **Benefits** for any one period of disability will not exceed the **maximum period of benefits** shown in the **schedule**. **Benefits** for any portion of a **period of disability** less than 1 week will be paid at the rate of 1/7 of the weekly benefit per **calendar day** of **disability**.

2. If a **covered person** becomes **disabled**, **we** will pay **benefits** as follows:

   a. For **disability** due to **illness or injury** the **benefits** begin on the 8th consecutive full **calendar day** of **disability** due to the **illness or injury**.

   b. For **disability** due to **accidental injury** the **benefits** begin on the 1st full **calendar day** of **disability** due to the **accidental injury.**

3. If an **employee** is no longer **actively at work** due to **disability**, **benefits** for a **period of disability** will not terminate if the **policy** remains in force and premiums are paid for the lesser of:

   a. 3 **months**; or

   b. the **period of disability**.

4. Termination of coverage for the **employee** for any reason other than no longer being **actively at work** due to **disability** will terminate **benefits**. This includes termination of coverage for the **employee** or termination of the **policy** by the **employer**.

5. If the event is not listed in this section or is excluded in Section V - Exclusions, that event is not covered and **benefits** are not payable under the **policy**. Any **covered event** specifically listed is only covered by that specific listing and not any general listing of **covered events**.

SECTION V - EXCLUSIONS

Words and phrases appearing in **bold** type have special meaning as set forth in Section VI - Definitions.

The following exclusions apply to all coverages described in the **policy**. Coverage is not provided for and no **benefits** will be paid for:

1. **Benefits** for events that are not listed as **covered events** in Section IV - **Covered Events**.
2. **Disability** when a **covered employee's** coverage was not in effect under the **policy**. This includes **disability** either prior to the effective date of coverage or after such coverage ends. This does not include a termination of coverage because the **employee** is not **actively at work** due to **disability** as long as premium is paid. If an employee is no longer **actively at work** due to **disability**, **benefits** for a **period of disability** will not terminate if the **policy** remains in force and premiums are paid for the lesser of:
   a. 3 **months**; or
   b. the **period of disability**.
3. **Disability** when the **covered employee** is not under the **regular care** of a **physician**.
4. **Disability** caused or contributed to by the **covered employee's** commission of or attempt to commit a felony.
5. **Disability** caused or contributed to by the **covered employee** being engaged in an illegal activity.
6. **Disability** caused or contributed to by the **covered employee's** commission of civil or criminal assault or battery.
7. **Disability** while a **covered employee** is on active duty in the Armed Forces including the National Guard.
8. **Disability** related to the **covered employee's** job to the extent it is covered or is required to be covered by **Workers' Compensation**. This exclusion applies to any **disability** that is covered or is required by law or regulation to be covered by **Workers' Compensation**. This exclusion applies if coverage under **Workers' Compensation** is required by law or regulation and was not purchased by the **covered person's employer**. A **covered employee** must submit any potentially work related claims to his **Workers' Compensation** insurer. Coverage is not provided for potentially work related claims that are not submitted to the **Workers' Compensation** insurer.

   If the **covered employee** enters into a settlement giving up his right to recover past or future wage loss under **Workers' Compensation**, **we** will not pay past or future wage loss that is the subject of or related to that settlement. .
9. Coverage under the **policy** will not duplicate coverage provided or required to be purchased or provided under federal, state, or local laws, regulations or programs. **We** will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion applies whether or not the **covered employee** chooses to waive his rights to these programs.
10. **Disability** claims that are submitted more than one year after a **disability** begins.
11. **Disability** caused by or arising out of acts of war.
12. **Disability** certified by a **close relative** or member of the **covered employee's** household or legal guardian of the employee who received the service. "Member of the **covered employee's** household" means anyone who lives in the same household or who was claimed as a tax deduction for the year during which the service was provided.
13. **Disability** beginning while held detained or imprisoned in a local, state or federal penal or correctional institution or while in the custody of law-enforcement officials. **Employees** on work release are not considered to be held, detained or imprisoned.
14. **Disability** arising out of, or related to any intentionally self-inflicted bodily injury.

SECTION VI - DEFINITIONS

Words and phrases appearing in **bold** type in the **policy** have special meaning as set forth below.

1. **Accidental Injury**

   means bodily injury caused by something unforeseen, unexpected, unusual, extraordinary or phenomenal, taking place not according to the usual course of things or events that results in **disability** within 5 calendar days.

2. **Active Work / Actively At Work**

   means an **employee** is performing all of the duties of the job with an **employer** for a minimum of 30 hours per **week**. An **employee** will be considered **actively at work** on:

   a. Any scheduled work day he is performing his regular duties for the **employer** at the **employer's** place of business or a location where his **employer** requires him to travel; or

   b. Any day of a paid vacation; or

   c. Any regularly scheduled non-working day, provided that the **employee** was at work on the last regular working day prior to that date.

3. **Authorized representative**

   means the person designated by a **covered employee** to contact **us** regarding a **grievance**. The designation must be in writing, specifically authorize contact with **us** regarding a **grievance** and be signed by the **covered employee**.

4. **Beneficiary**

   means the **covered employee's spouse**, mother, father, child or children, brothers or sisters, or executor or administrator of the **covered employee's** estate.

5. **Benefits**

   means the amount payable for **disability** that qualifies for coverage under the **policy**.

6. **Calendar Day**

   means the period starting at 12:01 a.m. Central Standard Time on any day and ending at midnight on that day.

7. **Close Relative**

   means:

   a. **Spouse**;

   b. **Covered employee's** child, brother, sister, or parent; and/or

   c. **Covered employee's spouse's** child, brother, sister or parent.

8. **Covered Employee**

   means an **employee** who is eligible for coverage under the **policy**, has applied for coverage and for whom a premium is paid to **us**.

9. **Covered Event**

   means **disability** caused by an **accidental injury** or an **illness or injury**.

10. **Disabled** or **Disability**

    An **employee** will be considered **disabled** if because of an **illness or injury** or **accidental injury**:

    a. He is unable to perform the basic duties of his occupation; and

    b. He is not performing any work or engaging in any other occupation for wage or profit; and

    c. He is under the **regular care** of his **physician**.

11. **Employee**

means someone who is **actively at work** in an **employer's** business. **Employee** does not include owners, shareholders or officers of the business who are not **actively at work** in the business. The **employee** must be reasonably compensated and his **employer** must report his earnings as required for Social Security. Temporary **employees**, consultants, advisors and other similar individuals do not qualify as **employees**.

12. **Employer**

means an **employer** who, in order to provide group health coverage to eligible **employees**, purchased the **policy** or participates in a multiple employer trust that purchased the **policy**.

13. **Grievance**

means any dissatisfaction with the administration or claims practices of or provision of service by **us** which is expressed in writing by or on behalf of a **covered employee**.

14. **Illness or Injury**

means any bodily disorder, bodily injury, disease or **mental illness**. This includes pregnancy.

15. **Maximum period of benefits**

means the longest time **benefits** will be paid for any one **period of disability**. The **maximum period of benefits** is shown in the **schedule**.

16. **Mental Illness**

means a condition that manifests symptoms for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause.

In determining whether or not a particular condition is a **mental illness**, **we** may refer to the edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association that is most current at the time the **mental illness** is diagnosed.

17. **Month**

means the period starting at 12:01 a.m. Central Standard Time on the 1st day of a given calendar **month** and ending at midnight on the last day of the calendar **month**.

18. **Period of Disability**

means the time a **covered employee** is **disabled.** If a **covered person** returns to work after a **period of disability** but becomes **disabled** again the second **period of disability** will be considered a continuation of the original **period of disability** for purposes of applying the **benefit** limits in the following situations:

a. if the **disability** is due to or related to same **illness or injury** or **accidental injury** as the original **disability** and the **covered employee** was **actively at work** for less than 2 months between periods of **disability**;

b. if the **disability** is not due to or related to the same **illness or injury** or **accidental injury** as the original **disability** and the **covered employee** was **actively at work** for less than 1 **calendar day** between **periods of disability**.

19. **Physician**

means a licensed medical doctor. For **mental illness** services, **physician** includes a licensed psychologist. When **we** are required by law to cover the services of any other licensed medical professional under the **policy**, a **physician** also includes such other licensed medical professional who:

a. Is acting within the lawful scope of his license; and

b. performing a service that is covered by the **policy**.

20. **Policy**

means policy forms, amendments and riders that constitute the agreement regarding the **benefits**, exclusions and other conditions.

21. **Proof of Good Health**

means satisfactory proof, as determined by **us**, that the **employee** is acceptable for coverage.

22. **Regular Care**

means a planned program of observation and treatment of the **illness or injury** or **accidental injury** causing **disability** carried out by a **physician** according to current standards of medical practice.

23. **Schedule**

    means the **Schedule** of Benefits attached to the **policy**.

24. **Spouse**

    means a person of opposite gender at birth, legally married to a **covered employee**.

25. **Waiting Period**

    means the period of time that must pass before coverage begins for an eligible **employee** who enrolls for the **policy**.

26. **Week** or **Weekly**

    means the 7-day period from Sunday through Saturday.

27. **Weekly Benefit**

    means the amount payable as **benefits** for each **week** of **disability**. The amount is calculated by multiplying the **weekly wage** by the percentage of the **weekly wage** payable as **benefits** shown in the **schedule** minus deductions required by state or federal law.

28. **Weekly Wage**

    means the amount of wages or salary paid by the **employer** to the **covered employee** each **week**. **Weekly wage** does not include bonuses, dividends, or incentive compensation.

    a. If the **covered employee** is paid on an hourly basis, the **weekly wage** is his base hourly wage multiplied by the number of hours he is scheduled to work each **week**.

    b. If the **covered employee** is paid a salary, the **weekly wage** is his current annual salary divided by 52.

    c. If the **covered employee** is paid solely by commission, the **weekly wage** is the lesser of any guaranteed minimum **weekly** commission or the average commission paid to him in the last 12 **weeks**.

29. **Workers' Compensation**

    means insurance **benefits** mandated under state **Workers' Compensation** laws.

SECTION IX - **GRIEVANCE** AND APPEAL PROCEDURES

Words and phrases appearing in **bold** type have special meaning as set forth in Section VIII - Definitions.

1. SUBMISSION OF **GRIEVANCES**

   Initially **grievances** should be submitted to our [Medical Benefits & Services Appeals Department] at:

   [Medical Benefits & Services Appeals]
   [Federated Mutual Insurance Company]
   [P.O. Box 328]
   [Owatonna, MN 55060]
   [Fax: 507-446-4723]
   [E-mail: healthappeals@fedins.com]

   After that review is completed, a second level **grievance** can be submitted to **our**.[Medical Benefits & Services Appeals]. A **covered employee** can also contact the local U.S. Department of Labor Office or the Arkansas Insurance Department to submit a **grievance** or complaint.

   A **covered employee** or **beneficiary** can appoint an **authorized representative** to act on his behalf in pursuing a **grievance**. The appointment of an **authorized representative** for handling **grievances** must be in writing and signed by the **covered employee** or **beneficiary**.

   Initial **grievances** must be submitted within 180 calendar days of the event giving rise to the **grievance**. The event giving rise to the **grievance** can be a notice of **benefit** determination, a notice of rescission of coverage, an administrative action by **us** or the provision of another service by **us**. For a **grievance** related to a notice of **benefit** determination or a notice of rescission of coverage, the date of the event is printed on the notice. For a **grievance** related to an administrative action by **us**, the date of the event is the date **we** took the administration action. For a **grievance** related to the provision of another service by **us**, the date of the event is the date **we** provided the service.

   Second level **grievances** must be submitted within 60 calendar days of the date printed on the written notice of the initial **grievance** decision.

2. INITIAL **GRIEVANCE** PROCEDURE

   When an initial **grievance** is received by our [Medical Benefits & Services Appeals Department], the following procedure will be used.

   a. Written acknowledgment of the **grievance** will be sent to the **covered employee**, **beneficiary** and/or the **authorized representative** within 3 working days. This shall include the name, address and phone number of the person handling the **grievance** and information on how to submit written material.

   b. The person reviewing the **grievance** will not be the same person who initially reviewed the claim. .

   c. An investigation will be completed and a decision made within 30 calendar days.

   d. Written notice of the decision will be sent to the **covered employee** and/or the **authorized representative**. That notice shall include:

      i. The specific reason for **our** decision.

      ii. The specific policy provisions applicable to the **grievance**.

      iii. Any internal guidelines used in making the decision.

      iv. Information on how to file a second level **grievance** and the right to sue after internal **grievance** procedures are completed by **us**.

      v. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and the Arkansas Insurance Department."

      vi. In states where the **covered employee** has a right to review by the state regulatory agency, information on how to obtain that review.

3. SECOND LEVEL **GRIEVANCE** PROCEDURE

A second level **grievance** is initiated by sending a request for review to:

[Medical Benefits & Services Appeals]
[Federated Mutual Insurance Company]
[P.O. Box 328]
[Owatonna, MN 55060]
[Fax: 507-446-4723]
[E-mail: healthappeals@fedins.com]

Or by calling [507-455-5200] or toll free [800-533-0472] and asking for the [Medical Benefits & Services Appeals Department].

Our [Medical Benefits & Services Appeals Department] will complete this review.

When a second level **grievance** is received by **our** [Medical Benefits & Services Appeals Department], the following procedure will be used.

a. Written acknowledgment of the **grievance** will be sent to the **covered employee** and/or the **authorized representative** within 3 working days. This shall include the name, address and phone number of the person handling the **grievance** and information on how to submit written material.

b. The person reviewing the **grievance** will not be the same person who initially reviewed the claim.

c. An investigation will be completed and a decision made within 30 calendar days.

d. Written notice of the decision will be sent to the **covered employee** and/or the **authorized representative**. That notice shall include:

   i. The specific reason for **our** decision.

   ii. The specific policy provisions applicable to the **grievance**.

   iii. Any internal guidelines used in making the decision.

   iv. Information on how to obtain copies of documents **we** have on the **grievance**.

   v. Information on the right to sue after internal grievance procedures are completed by **us**.

   vi. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and the Arkansas Insurance Department."

   vii. In states where the **covered employee** has a right to review by the state regulatory agency, information on how to obtain that review.

4. RECORDKEEPING

We will maintain a record of all **grievances** filed and their resolution. The record will include the name of the **covered employee**, date of the **grievance**, nature of the **grievance**, date of response/resolution and summary of the resolution. Copies of all **grievances**, investigative material and response letters will be kept with the **grievance** record. The **grievance** record will be maintained in the claims office for a minimum of 5 years.

Periodically, **we** will review the **grievance** record. This review will include analysis of the appropriateness of responses.

SCHEDULE OF BENEFITS

Words and phrases appearing in **bold** type have special meaning as set forth in Section VI - Definitions.

Payment of **benefits** for **covered events** are subject to the following limitations:

	Amount
Maximum period of **benefits**	[26 Weeks]
Portion of **weekly wage** payable as **benefits**	[2/3]
Maximum weekly **benefit**	[$100 - $500]

Benefits for any one **period of disability** will not exceed the **maximum period of benefits** shown above**.**

Benefits for any **week** of **disability** will not exceed the maximum **weekly benefit**.

Benefits for any portion of a **period of disability** less than 1 **week** will be paid at the rate of 1/7 of the **weekly benefit** per **calendar day** of **disability**.

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	10/14/2011

Comments:

Attachment:

AR Flesch Score Certification.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	10/14/2011

Comments:

Attachment:

4420 (01-09).pdf

121 East Park Square
P.O. Box 328 • Owatonna, MN 55060
Phone: (507) 455-5200 • 800-533-0472

FEDERATED MUTUAL INSURANCE COMPANY

READABILITY CERTIFICATION
for the state of
ARKANSAS

GI 03 10 (01-12 ed.)
GI 03 11 (01-12 ed.)

To the best of my knowledge and belief, these forms meet the Flesch minimum reading ease score of the Arkansas readability requirements with a combined score of 56.

2011.09.12 13:54:08 -05'00'

Jeanne H. Hankerson First Vice President

September 12, 2012

FEDERATED INSURANCE®

Internal use only: Acct #_____

☐ Federated Life Insurance Company
☐ Federated Mutual Insurance Company
Attn: Group Health Administration
1929 S. Cedar, Owatonna, MN 55060
Toll Free: 1-800-377-9154 Fax: 507-446-4697

Employee Enrollment and Record Form

Please print in black ink

Please complete this form carefully. The effective date may be delayed if vital information is missing.

SECTION 1: EMPLOYEE INFORMATION

Employee's Last Name _____ First Name _____ Middle Initial ____ ☐ Single ☐ Married Number of dependent children: _____

Social Security # _____ **Gender** ☐ M ☐ F **Date of Birth** _____ **Height** ____ ft. _____ in **Weight** _____ lbs

Home street address City/State/Zip

Employer's Name City/State/Zip

Job Title	Are you an owner or officer? ☐ Yes ☐ No	**Date employed full-time** (mm/dd/yy):	**Hours worked per week**

Are you (the employee) actively working on a **full-time basis** and receiving a W2 from this employer? ☐ Yes ☐ No

If no longer receiving a wage **from this employer**, what was your last date of employment? (mm/dd/yy) _____ ☐ N/A

How may we contact you if we need more information? Cell Phone ( ) Home phone ( )
Work phone ( ) Best time to call? _____ am/pm (circle one)

SECTION 2: DEPENDENT INFORMATION – *List all dependents applying for coverage*

(Eligible dependents include legal spouse, unmarried children under age 25 or full-time students and disabled children of any age.)

Spouse's Last Name _____ **First Name** _____ **Middle Initial** ____ **Date of Marriage** _____

Social Security # _____ Gender ☐ M ☐ F Date of Birth _____ Height _____ ft. ____in Weight _____ lbs

Dependent Child(ren) Names (First, Middle Initial, Last)	Social Security Number	Date of Birth (mm/dd/yy)	Gender	Relationship to Employee	Resides in your home?
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No

SECTION 3: BENEFIT SELECTION

(The availability of benefits are based on those offered by your employer)

Select Employee Benefits (Choose One): **AND** **Select Dependent Benefits** (Choose One):

- ☐ All coverages offered by employer
- ☐ Life, Dental, & Short Term Disability Only (if offered)
- ☐ Currently enrolled in COBRA or State Continuation
- ☐ No coverage **(complete Section 4)**

- ☐ Spouse and dependent children
- ☐ Spouse only
- ☐ Dependent children only
- ☐ No coverage **(complete Section 4)**

SECTION 4: DECLINING COVERAGE

(Complete if declining coverage for you, your spouse, or your dependent children)

I am declining health coverage for (check all that apply) ☐ myself ☐ my spouse ☐ my children
because I/we are (choose one) ☐ covered elsewhere. Name of insurer:_____
☐ other Explain: _____

IMPORTANT: DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you are otherwise eligible and request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If no additional premium is required for a new dependent, the 30-day enrollment requirement does not apply.

SECTION 5: LIFE INSURANCE BENEFICIARY

(Complete only if applying for life insurance)

Primary Beneficiary:

Legal Name Relationship

Date of Birth Address

Contingent Beneficiary(ies):

Legal Name Relationship

Legal Name Relationship

Continue on Reverse Side →

SECTION 6: HEALTH INFORMATION

(Answer each of the following for **you, your spouse, and each dependent** listed in section 2)

During the *past 5 years*, has any person had, been told they have, or received treatment or follow-up care for:		**Circle all that apply and provide details in Sections 7 and 8**
1. ☐ Yes ☐ No	**Heart/Circulatory**	High Blood Pressure, High Cholesterol, Stroke, Heart Attack, Angioplasty, Aneurysm, Vascular Disease, By-Pass Surgery, Irregular Heart Beat, Heart Valve Problems, Anemia, Blood Disorder, Other
2. ☐ Yes ☐ No	**Lung/Respiratory**	Allergies, Asthma, Cystic Fibrosis, Emphysema, Sleep Apnea, COPD, Other
3. ☐ Yes ☐ No	**Intestinal/Endocrine/ Digestive/Liver**	Diabetes (Type I or II), Hepatitis, Colitis, Ulcerative Colitis, Pancreatitis, Cirrhosis, Diverticulitis Hiatal Hernia, Crohn's Disease, Thyroid Disorder, Other
4. ☐ Yes ☐ No	**Urinary/Kidney**	Kidney Stones, Dialysis, Polycystic Kidneys, Infection, Renal Failure, Enlarged Prostate, Other
5. ☐ Yes ☐ No	**Brain/Nervous**	Multiple Sclerosis, Epilepsy, Seizures, Cerebral Palsy, Paralysis, Brain Injury, Other
6. ☐ Yes ☐ No	**Skeletal/Muscle**	Back/Neck Pain, Hernia, Fibromyalgia, Lupus Muscular Dystrophy, Osteoarthritis, Rheumatoid Arthritis, Joint Replacement, Artificial Limb, Other
7. ☐ Yes ☐ No	**Mental Health**	Anxiety, Depression, Alcohol/Drug Abuse, ADD/ADHD, Bipolar, Anorexia/Bulimia, Other
8. ☐ Yes ☐ No	**Cancer/Tumor/Growth**	Cancer or Tumor (provide location below), Benign Polyp, Hodgkins, Leukemia, Other
9. ☐ Yes ☐ No	**Transplant**	If transplant complete: Organ _____ Date of Transplant _____ If transplant pending: Organ _____ Date Expected _____
10. ☐ Yes ☐ No	Has any person been diagnosed or treated by a physician for AIDS, ARC, or AIDS related condition?	
11a. ☐ Yes ☐ No	Are you or an eligible dependent (even if not enrolling for coverage) an expectant parent? If yes, due date is :_____	
11b. ☐ Yes ☐ No	Are there previous or current complications, previous or current multiple births, or a C-section expected (Circle all that apply & explain in Sections 7 and 8).	
12. ☐ Yes ☐ No	Is any person to be insured currently disabled, hospitalized, on medical leave, or handicapped? (circle all that apply)	
13. ☐ Yes ☐ No	Other than #1-12 above has any person received medical advice or treatment for any condition during the past 5 years? If yes, explain in Sections 7 and 8.	
14. ☐ Yes ☐ No	Is there any medical condition that will require treatment or surgery in the next 24 months on any person to be insured? If yes, explain in Sections 7 and 8.	
15. ☐ Yes ☐ No	Tobacco Use: By whom? Type? Start Date? Stop Date?	
16. ☐ Yes ☐ No	Are any of the above conditions or medications currently covered under Medicare, worker's compensation, auto, or liability coverage? (If yes, circle coverage that applies)	List the condition(s) _____

SECTION 7: Complete for ALL medical conditions circled and/or checked above

(Please use an additional page, if needed)

Question #	Person's Name	Diagnosis (name of injury or illness)	Treatment Received	Date of Onset	Date of full recovery or "Not yet recovered"

SECTION 8: MEDICATIONS: Complete for each person applying for coverage

(List ALL medications taken, use an additional page if needed)

Question #	Person's Name	Medication	Reason Prescribed	# per day	Dosage (mg/gm)	Date first prescribed	Still Prescribed?
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

SECTION 9: EMPLOYEE AUTHORIZATION AND REPRESENTATION

(Read this section, sign, and date this form even if not enrolling for coverage)

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Agreement: I certify that I have read or have had read to me the completed form and the above answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any certificate of insurance issued and that the insurance company may withdraw the coverage for which I am applying and may consider such coverage as having never been in effect, if any information is substantially incomplete or incorrect.

I hereby enroll (or decline to be enrolled) in group insurance plan(s) through Federated Insurance. With my enrollment, I authorize my employer to deduct from my earnings an amount sufficient for my contribution, if any, toward the group insurance premiums.

Employee's Signature	Date Signed	Spouse's Signature (if applying for coverage)	Date Signed
_____	_____	_____	_____

This form MUST be dated and signed

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
Filing Company:	*Federated Mutual Insurance Company*	*State Tracking Number:*	*49792*
Company Tracking Number:			
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/13/2011	Form	Cover Page	10/13/2011	GI 03 10 _01-12 ed._.pdf (Superceded)
09/13/2011	Form	Cover Page	10/13/2011	GI 03 11 _01-12 ed._.pdf (Superceded)
09/15/2011	Form	General Provisions	10/13/2011	GI 00 01 _01-12 ed._.pdf (Superceded)
09/13/2011	Form	General Provisions	09/15/2011	GI 00 01 _01-12 ed._.pdf (Superceded)
09/13/2011	Form	Enrollment and Effective Date	09/15/2011	GI 00 02 _01-12 ed._.pdf (Superceded)
09/13/2011	Form	Termination of Coverage	09/15/2011	GI 00 03 _01-12 ed._.pdf (Superceded)
09/13/2011	Form	Covered Events	09/15/2011	GI 00 04 _01-12 ed._.pdf (Superceded)
09/15/2011	Form	Exclusions	10/13/2011	GI 00 05 _01-12 ed._.pdf (Superceded)
09/13/2011	Form	Exclusions	09/15/2011	GI 00 05 _01-12 ed._.pdf (Superceded)

SERFF Tracking Number:	*FEMC-127624086*	*State:*	*Arkansas*
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Product Name:	*Group Short-Term Disabiliy*		
Project Name/Number:	*DIPolicy2012/DIPolicy2012*		

09/13/2011	Form	Definitions	09/15/2011	GI 00 06 _01-12 ed._.pdf (Superceded)
09/13/2011	Form	Grievance and Appeals Procedures	10/13/2011	GI 00 07 _01-12 ed._.pdf (Superceded)

FEDERATED MUTUAL

INSURANCE COMPANY
HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060
Phone: 800-533-0472

GROUP DISABILITY INCOME POLICY

Policyholder: _____

_____

_____

Policy Effective Date: _____
at 12:01 a.m. Central Standard Time

Policy Anniversary: _____ and annually each year thereafter.

Policy Number: _____

This policy is delivered in Arkansas and is governed by its laws.

CONSIDERATION. The **policy** is issued to the **policyholder** in consideration of the application and payment of premiums.

MEMBER OF THE COMPANY. By virtue of this **policy**, the **policyholder** is a member of Federated Mutual Insurance Company. **Our** annual meetings are held at the Home Office on the third Tuesday in April at 10:00 A.M.

Secretary President

INDEX

FEDERATED MUTUAL

INSURANCE COMPANY

121 East Park Square ▪ Owatonna, MN 55060

GROUP DISABILITY INCOME CERTIFICATE OF COVERAGE

Employee:
IDN:
Coverage:
Effective Date:
Employer:
Group No.:

POLICY NUMBER:
POLICYHOLDER:

The **policy** is delivered in Arkansas and is governed by its laws.

The insurance is effective on the date shown above, provided the **employee** meets the eligibility requirements of the **policy**.

The principal provisions of the **policy** are set forth in the following pages. This certificate is not the policy. It replaces any other certificate previously issued to the **employee** under the above **policy** number. The terms and conditions of the **policy** control the coverage provided.

Words and phrases appearing in bold type throughout the certificate have special meaning as set forth in the Definitions (form GI 00 06).

Executed by Federated Mutual Insurance Company at Owatonna, Minnesota.

SECRETARY **PRESIDENT**

INDEX

Various provisions in this document restrict coverage. Read the entire document carefully to determine rights, duties and what is and is not covered.

The words "**we**", "**us**" and "**our**" refer to Federated Mutual Insurance Company.

The word "**policyholder**" means the organization or employer listed as such on the face page.

Other words and phrases appearing in **bold** type have special meaning. Refer to Section VI - Definitions.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

1. **BENEFITS**

   We agree to pay **benefits** as provided in the **policy** to **covered employees**.

2. **POLICY** CHANGES

   Changes may be made in the **policy** only by **us** acting through **our** President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the **policy**.

3. ENTIRE CONTRACT

   The entire contract will be made up of the **policy**, the application of the **policyholder**, the applications of the **employers** and the applications of **covered employees**. All references to statements, applications, writings, and signatures as they apply to the terms of the **policy** will include their representations in electronic form, as agreed to by both **us** and the **covered person**, **employer**, or **policyholder** who made the statement, application, writing or signature.

4. INSURANCE DATA

   The **employer** will give **us** all of the data that **we** need to calculate the premium and all other information that **we** may reasonably require. **We** have the right to examine the **employer's** records relative to the **policy** at any reasonable time while the **policy** is in effect. **We** also have this right until all rights and obligations under the **policy** are finally determined.

5. STATEMENTS NOT WARRANTIES

   All statements made by the **policyholder** or **employer** or **covered employee** will, in the absence of fraud, be deemed representations and not warranties. No statement made by the **policyholder** or **employer** or **covered employee** to obtain coverage will be used to avoid or reduce the coverage unless it is made in writing and is signed by the policyholder or employer or **covered employee** and a copy is sent to the **policyholder** or **employer** or **covered employee** or his **beneficiary**.

6. MISSTATEMENT

   If information in the application of a **covered employee** has been misstated, the corrected age will be used to determine whether insurance is in force under the **policy** and in what amount. If insurance remains in force an equitable adjustment of premium may be made.

7. RIGHT TO CONTEST

   We have no right to contest the coverage of an **employer** on the basis of any statement made in the **employer's** application after the **employer's** coverage has been in force for two years. Before then **we** have the right to contest only if the statement was in writing on a form signed by the **employer** and a copy of it is given to the **employer.** Coverage will only be rescinded for fraud or intentional misrepresentation of a material fact made by the **employer** in his application. Nothing in this provision shall keep **us** from using at any time a defense based on **policy** provisions that relate to eligibility for coverage.

   We have no right to contest the coverage of a covered employee on the basis of any statement made in a **covered employee's** application after the **covered employee's** coverage has been in force for two years. Before then **we** have the right to contest only if the statement was in writing on a form signed by the **covered employee** and a copy of it is given to the **covered employee** or his **beneficiary**. Coverage will only be rescinded for fraud or intentional misrepresentation of a material fact made by the **covered person** in his application. Nothing in this provision shall keep us from using at any time a defense based on **policy** provisions that relate to eligibility for coverage.

8. NOTICE OF CLAIM

Written notice of claim must be given to **us** within 30 days after the occurrence or commencement of any loss covered by the **policy**, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the **covered employee** to **us** at 121 East Park Square, Owatonna, Minnesota 55060, or to any of **our** authorized agents, with information sufficient to identify the **covered employee**, shall be deemed notice to **us**.

9. CLAIM FORMS

Upon receipt of a notice of claim, **we** will furnish to the **covered employee** forms for filing proof of loss. If such forms are not furnished within 15 days after we receive the notice of claim, the **covered employee** shall be deemed to have complied with the requirements of the **policy** regarding proof of loss, if within 90 days the **covered employee** gives **us** written proof covering the occurrence, the character and the extent of the loss for which claim is made.

10. PROOF OF LOSS

Written proof of loss must be furnished to us within 90 days after the date of loss. Failure to furnish such proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, shall the proof of loss be submitted more than one year from the time proof is otherwise required.

11. TO WHOM PAYABLE

All **benefits** are payable to the **covered employee**.

If any **employee** to whom **benefits** are payable is a minor or, in **our** opinion, is not able to give valid receipt for any payment due him, such payment will be made to his legal guardian.

If a **covered employee** dies while **benefits** remain unpaid, **we** may choose to make direct payment to the **covered employee's beneficiary**.

Payment in the manner described above will release **us** from all liability to the extent of any payment made.

12. TIMING OF BENEFIT PAYMENTS

Initial **benefits** for **disability** are payable within 30 **calendar days** of the date **we** receive a clean claim. If additional information is needed to process a claim, a request will be sent to the **provider** or **covered employee** within 30 **calendar days**. Additional **benefits** for **disability** will be paid every 14 days.

A "clean claim" is one where no additional documentation or information is needed to determine eligibility or process the claim. "Clean claim" does not include claims for **disability** during times when premium is not paid or where fraud is suspected.

13. PHYSICAL EXAMINATIONS AND AUTOPSY

We, at **our** expense, shall have the right and opportunity to examine the **covered employee** when and as often as **we** may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

14. LEGAL ACTIONS

No action at law or in equity will be brought to recover on the **policy** until at least 60 days after completion of all appeals as outlined in Section VII - **Grievance** and Appeal Procedure. No action will be brought at all unless brought within 3 years after the time within which the appeals are complete.

15. **PHYSICIAN** / PATIENT RELATIONSHIP

The **covered employee** will have the right to choose any **physician** who is practicing legally. **We** will in no way disturb the **physician** / patient relationship.

16. CERTIFICATES

At **our** option **we** will issue to the **employer** for delivery to each **covered employee** an individual certificate or **we** will deliver to each **covered employee** an individual certificate. The certificate will show the **benefits** provided under the **policy** and to whom **benefits** will be paid. Nothing in the certificate will change or void the terms of the **policy**.

17. SEVERABILITY

Any provision of the **policy** that is prohibited by law shall be void and be without force or effect. But this will not invalidate the enforceability of any other term, condition or provision of the **policy**.

18. SUBROGATION

To the extent allowed by law, when **we** have provided **benefits** to or on behalf of a **covered employee** due to **disability**, **we** will have subrogation and/or reimbursement rights. If a **covered employee** recovers damages from a third party who is liable for the **disability**, the **covered employee** will reimburse us for amounts **we** have paid as **benefits** for that **disability**. If a **covered employee** recovers damages for the **disability** from any other insurance, the **covered employee** will reimburse **us** for amounts **we** have paid as **benefits** for that **disability**.

The **covered employee** will not prejudice **our** right to recover from a liable third party. Entering into a settlement or compromise arrangement without **our** prior consent will be deemed to prejudice **our** rights. A **covered employee** must notify us anytime he has a claim against a third party for **disability** for which **we** have paid **benefits**.

This subrogation provision will apply to any settlement or judgement received by the **covered employee**. **We** are entitled to full recovery of **benefits we** paid even if:

a. The third party does not admit liability; or

b. The settlement or judgment does not identify any amounts paid as income loss.

We are not required to participate in any legal action by the **covered employee** to recover damages. **We** are not required to pay any fees or costs incurred by the **covered employee** or his attorney to recover damage

19. PREMIUMS

a. PREMIUM PAYMENT. The premium for each **covered employee** will be due prior to the first day of each **month**. All premiums are payable in advance by the **employer** at **our** Home Office or to **our** designated premium collection agent. All premiums must be made payable to 'Federated Mutual Insurance Company". **Our** insurance agents are not authorized to collect premiums other than the first premium.

b. MONTHLY PREMIUM STATEMENT. A monthly premium statement will be prepared prior to the premium due date. This monthly premium statement will show the premium due and will reflect any pro rata premium charges and credits due to changes in the number of **covered employees** and changes in coverage that took place in the preceding **month**.

c. CHANGES IN PREMIUM RATES. **We** may change any premium rate from time to time with at least 31 days advance written notice. No change in rates will be made until 12 **months** after the date an **employer** purchases in the **policy**.

However, **we** may change rates immediately only if, in **our** opinion, **our** liability is altered:

i. by any change in state or federal law; or

ii. by a revision in the insurance under the **policy** including but not limited to changes of over 20% in the number of **covered employees** with any one **employer**.

Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

If an increase in rates takes place on a date that is not a premium due date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next premium due date. If a decrease in rates takes place on a date that is not a premium due date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next premium due date.

d. GRACE PERIOD. If, before a premium due date, the **employer** has not given written notice to us that the coverage for the **employer** is to terminate, a grace period of 31 days will be granted for the payment of each premium after the first premium. The coverage will stay in force during that time. If **we** do not receive the premium payment by the end of the grace period, the coverage will automatically terminate at the end of the grace period. However, if the **employer** has given written notice in advance of an earlier date of termination, the insurance will terminate as of the earlier date. The **employer** will be liable to us for any unpaid premium for the time the coverage was in force including the grace period.

e. INCORRECT PREMIUM PAYMENT. Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has terminated, will be refunded without interest when requested by the **employer**. These premiums will not be refunded for more than the **month** in which **we** are notified of the termination of coverage.

f. NON-PARTICIPATING PREMIUM REFUNDS. The **policy** does not share in **our** surplus earnings.

Various provisions in this document restrict coverage. Read the entire document carefully to determine rights, duties and what is and is not covered.

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   The entire contract will be made up of the **policy**, the application of the **policyholder**, the applications of the **employers** and the applications of **covered employees**. All references to statements, applications, writings, and signatures as they apply to the terms of the **policy** will include their representations in electronic form, as agreed to by both **us** and the **covered person**, **employer**, or **policyholder** who made the statement, application, writing or signature.

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   If information in the application of a **covered employee** has been misstated, the corrected age will be used to determine whether insurance is in force under the **policy** and in what amount. If insurance remains in force an equitable adjustment of premium may be made.

7. RIGHT TO CONTEST

   We have no right to contest the coverage of an **employer** on the basis of any statement made in the **employer's** application after the **employer's** coverage has been in force for two years. Before then **we** have the right to contest only if the statement was in writing on a form signed by the **employer** and a copy of it is given to the **employer.** Coverage will only be rescinded for fraud or intentional misrepresentation of a material fact made by the **employer** in his application. Nothing in this provision shall keep **us** from using at any time a defense based on **policy** provisions that relate to eligibility for coverage.

   We have no right to contest the coverage of a covered employee on the basis of any statement made in a **covered employee's** application after the **covered employee's** coverage has been in force for two years. Before then **we** have the right to contest only if the statement was in writing on a form signed by the **covered employee** and a copy of it is given to the **covered employee** or his **beneficiary**. Coverage will only be rescinded for fraud or intentional misrepresentation of a material fact made by the **covered person** in his application. Nothing in this provision shall keep us from using at any time a defense based on **policy** provisions that relate to eligibility for coverage.

8. NOTICE OF CLAIM

Written notice of claim must be given to **us** within 30 days after the occurrence or commencement of any loss covered by the **policy**, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the **covered employee** to **us** at 121 East Park Square, Owatonna, Minnesota 55060, or to any of our authorized agents, with information sufficient to identify the **covered employee**, shall be deemed notice to **us**.

9. CLAIM FORMS

Upon receipt of a notice of claim, **we** will furnish to the **covered employee** forms for filing proof of loss. If such forms are not furnished within 15 days after we receive the notice of claim, the **covered employee** shall be deemed to have complied with the requirements of the policy regarding proof of loss, if within 90 days the **covered employee** gives **us** written proof covering the occurrence, the character and the extent of the loss for which claim is made.

10. PROOF OF LOSS

Written proof of loss must be furnished to us within 90 days after the date of loss. Failure to furnish such proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, shall the proof of loss be submitted more than one year from the time proof is otherwise required.

11. TO WHOM PAYABLE

All **benefits** are payable to the **covered employee**.

If any **employee** to whom **benefits** are payable is a minor or, in **our** opinion, is not able to give valid receipt for any payment due him, such payment will be made to his legal guardian.

If a **covered employee** dies while **benefits** remain unpaid, **we** may choose to make direct payment to the **covered employee's beneficiary**.

Payment in the manner described above will release **us** from all liability to the extent of any payment made.

12. TIMING OF BENEFIT PAYMENTS

Initial **benefits** for **disability** are payable within 30 **calendar days** of the date **we** receive a clean claim. If additional information is needed to process a claim, a request will be sent to the **provider** or **covered employee** within 30 **calendar days**. Additional **benefits** for **disability** will be paid every 14 days.

A "clean claim" is one where no additional documentation or information is needed to determine eligibility or process the claim. "Clean claim" does not include claims for **disability** during times when premium is not paid or where fraud is suspected.

13. PHYSICAL EXAMINATIONS AND AUTOPSY

We, at **our** expense, shall have the right and opportunity to examine the **covered employee** when and as often as **we** may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

14. LEGAL ACTIONS

No action at law or in equity will be brought to recover on the **policy** until at least 60 days after completion of all appeals as outlined in Section VII - **Grievance** and Appeal Procedure. No action will be brought at all unless brought within 3 years after the time within which the appeals are complete.

15. **PHYSICIAN** / PATIENT RELATIONSHIP

The **covered employee** will have the right to choose any **physician** who is practicing legally. **We** will in no way disturb the **physician** / patient relationship.

16. CERTIFICATES

At our option **we** will issue to the **employer** for delivery to each **covered employee** an individual certificate or **we** will deliver to each **covered employee** an individual certificate. The certificate will show the **benefits** provided under the **policy** and to whom **benefits** will be paid. Nothing in the certificate will change or void the terms of the **policy**.

17. SEVERABILITY

Any provision of the **policy** that is prohibited by law shall be void and be without force or effect. But this will not invalidate the enforceability of any other term, condition or provision of the **policy**.

18. SUBROGATION

To the extent allowed by law, when **we** have provided **benefits** to or on behalf of a **covered employee** due to **disability**, **we** will have subrogation and/or reimbursement rights. If a **covered employee** recovers damages from a third party who is liable for the **disability**, the **covered employee** will reimburse us for amounts **we** have paid as **benefits** for that **disability**. If a **covered employee** recovers damages for the **disability** from any other insurance, the **covered employee** will reimburse **us** for amounts **we** have paid as **benefits** for that **disability**.

The **covered employee** will not prejudice **our** right to recover from a liable third party. Entering into a settlement or compromise arrangement without **our** prior consent will be deemed to prejudice our rights. A **covered employee** must notify us anytime he has a claim against a third party for **disability** for which **we** have paid **benefits**.

This subrogation provision will apply to any settlement or judgement received by the **covered employee**. We are entitled to full recovery of **benefits we** paid even if:

a. The third party does not admit liability; or

b. The settlement or judgment does not identify any amounts paid as income loss.

We are not required to participate in any legal action by the **covered employee** to recover damages. **We** are not required to pay any fees or costs incurred by the **covered employee** or his attorney to recover damage

19. PREMIUMS

a. PREMIUM PAYMENT. The premium for each **covered employee** will be due prior to the first day of each **month**. All premiums are payable in advance by the **employer** at **our** Home Office or to **our** designated premium collection agent. All premiums must be made payable to 'Federated Mutual Insurance Company". **Our** insurance agents are not authorized to collect premiums other than the first premium.

b. MONTHLY PREMIUM STATEMENT. A monthly premium statement will be prepared prior to the premium due date. This monthly premium statement will show the premium due and will reflect any pro rata premium charges and credits due to changes in the number of **covered employees** and changes in coverage that took place in the preceding **month**.

c. CHANGES IN PREMIUM RATES. We may change any premium rate from time to time with at least 31 days advance written notice. No change in rates will be made until 12 **months** after the date an **employer** purchases in the **policy**.

However, we may change rates immediately only if, in our opinion, our liability is altered:

i. by any change in state or federal law; or

ii. by a revision in the insurance under the **policy** including but not limited to changes of over 20% in the number of **covered employees** with any one **employer**.

Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

If an increase in rates takes place on a date that is not a premium due date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next premium due date. If a decrease in rates takes place on a date that is not a premium due date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next premium due date.

d. GRACE PERIOD. If, before a premium due date, the **employer** has not given written notice to us that the coverage for the **employer** is to terminate, a grace period of 31 days will be granted for the payment of each premium after the first premium. The coverage will stay in force during that time. If **we** do not receive the premium payment by the end of the grace period, the coverage will automatically terminate at the end of the grace period. However, if the **employer** has given written notice in advance of an earlier date of termination, the insurance will terminate as of the earlier date. The **employer** will be liable to us for any unpaid premium for the time the coverage was in force including the grace period.

e. INCORRECT PREMIUM PAYMENT. Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has terminated, will be refunded without interest when requested by the **employer**. These premiums will not be refunded for more than the **month** in which **we** are notified of the termination of coverage.

f. NON-PARTICIPATING PREMIUM REFUNDS. The **policy** does not share in **our** surplus earnings.

SECTION II - ENROLLMENT & EFFECTIVE DATE

Words and phrases appearing in bold type have special meaning as set forth in Section VI - Definitions.

1. **EMPLOYER** ENROLLMENT

   An **employer** shall apply to become a covered **employer** or policyholder. The **employer** will become a covered **employer** or policyholder on the first day of the month coinciding with or following the date such **employer** applies subject to:

   a. Approval by us; and

   b. Meeting the participation requirements shown below; and

   c. Meeting the contribution requirements shown below.

2. PARTICIPATION REQUIREMENTS

   a. When the **employer** pays the entire premium for each **covered employee**, 100% of the eligible **employees** not covered under a separate unrelated employer's plan must be enrolled for coverage at all times.

   b. When **covered employees** contribute to the premium payment, a minimum of 85% of all eligible **employees** not covered under a separate unrelated employer's plan must be enrolled at all times.

   c. In addition, a minimum of two (2) eligible **employees** must always be insured under each **employer's** plan in order for coverage to be issued or continued.

3. CONTRIBUTION REQUIREMENTS

   When an **employer** does not pay the full premium for **covered employees**, the **employer** must pay a minimum of 70% of the premium for **covered employees**.

4. **EMPLOYEE** ELIGIBILITY

   a. An **employee** is eligible for coverage under the **policy** if he:

      i. is under age 70; and

      ii. is **actively at work;** and:

      iii. has completed the **waiting period** shown in the **employer's** application for coverage or was covered under the **employer's** prior plan on the day before the effective date of the **employer's** coverage with us; and

      iv. has submitted **proof of good health**.

   b. Once enrolled, an **employee** is eligible for coverage under the **policy** only if he is **actively at work**.

5. **EMPLOYEE** EFFECTIVE DATE

   a. Each eligible **employee** may elect coverage by completing and signing an application. The effective date of his coverage depends upon the date on which the **employee** elects the coverage.

      i. If elected on or before the date he becomes eligible, his coverage will be effective on the first day of the **month** after he becomes eligible.

      ii. If elected within 31 days after he becomes eligible, his coverage will be effective on the first day of the **month** after election.

      iii. If elected more than 31 days after he becomes eligible, his coverage will be effective on the first day of the **month** after **we** approve his application for coverage.

      iv. If his coverage ceased because he cancelled his payroll deduction, and he again elects to be insured, his coverage will be effective on the first day of the **month** after **we** approve his application for coverage.

   b. The **employee** must be **actively at work** on the effective date of his coverage for coverage to take effect.

   c. The **employee** must be **actively at work** on the effective date of any change in his coverage for such change in coverage to take effect.

SECTION III - TERMINATION OF COVERAGE

Words and phrases appearing in **bold** type have special meaning as set forth in Section VI - Definitions.

1. The **employer's** coverage under the **policy** will terminate at the earliest of the following dates:
   a. the date the **employer** fails to make any premium payment when due;
   b. the date the **employer** fails to comply with the **employer** contribution rules;
   c. the date participation requirements are no longer met;
   d. the date the **employer** commits fraud or intentionally misrepresents a material fact;
   e. for association groups, the date the membership of an **employer** in the association ceases; or
   f. the date we elect to discontinue the policy as permitted by state and federal law.
2. An **employee's** coverage will terminate on the earliest of the following dates:
   a. the date the **employer's** coverage terminates;
   b. the date the **employee** is not eligible for coverage;
   c. the date the **employee** does not make required premium contributions;
   d. the date the **policy** terminates;
   e. the date the **employee** reaches age 70.
3. The **employer** has the right to terminate coverage by providing us with advance written notice of his intent. The notice must be sent to us at the following address.

   Group Administration
   Federated Mutual Insurance Company
   PO Box 328
   Owatonna, MN 55060

   Coverage will terminate on the last day of the **month** in which **we** receive the **employer's** written notice of intent to terminate.
4. An **employee** has the right to terminate coverage by providing his employer with advance written notice of his intent. The **employer** must then notify us at the following address.

   Group Administration
   Federated Mutual Insurance Company
   PO Box 328
   Owatonna, MN 55060

   or by calling the automated termination line 800-377-9154.

   An **employee's** coverage will terminate on the last day of the **month** in which **we** receive the **employer's** notice of intent to terminate coverage for that **employee**.
5. GRACE PERIOD

   If, before a premium due date, the **employer** has not given written notice to us that the coverage for the **employer** is to terminate, a grace period of 31 days will be granted for the payment of each premium after the first premium. The coverage will stay in force during that time. If **we** do not receive the premium payment by the end of the grace period, the coverage will automatically terminate at the end of the grace period. However, if the **employer** has given written notice in advance of an earlier date of termination, the insurance will terminate as of the earlier date. The **employer** will be liable to **us** for any unpaid premium for the time the coverage was in force including the grace period.

SECTION IV - **COVERED EVENTS**

Words and phrases appearing in **bold** type have special meaning as set forth in Section VI - Definitions.

1. If a **covered event** happens to a **covered person**, we will pay benefits as provided in the **schedule**. Payment of **benefits** will be subject to provisions set forth in the **schedule**. **Benefits** for any one period of disability will not exceed the **maximum period of benefits** shown in the **schedule**. **Benefits** for any portion of a **period of disability** less than 1 week will be paid at the rate of 1/7 of the weekly benefit per **calendar day** of **disability**.
2. If a **covered person** becomes **disabled**, **we** will pay **benefits** as follows:
   a. For **disability** due to **illness or injury** the **benefits** begin on the 8th consecutive full **calendar day** of **disability** due to the **illness or injury**.
   b. For **disability** due to **accidental injury** the **benefits** begin on the 1st full **calendar day** of **disability** due to the **accidental injury.**
3. If an **employee** is no longer **actively at work** due to **disability**, **benefits** for a **period of disability** will not terminate if the policy remains in force and premiums are paid for the lesser of:
   a. 3 **months**; or
   b. the **period of disability**.
4. Termination of coverage for the **employee** for any reason other than no longer being actively at work due to **disability** will terminate **benefits**. This includes termination of coverage for the **employee** or termination of the **policy** by the **employer**.
5. If the event is not listed in this section or is excluded in Section V - Exclusions, that event is not covered and **benefits** are not payable under the **policy**. Any **covered event** specifically listed is only covered by that specific listing and not any general listing of **covered events**.

SECTION V - EXCLUSIONS

Words and phrases appearing in **bold** type have special meaning as set forth in Section VI - Definitions.

The following exclusions apply to all coverages described in the **policy**. Coverage is not provided for and no **benefits** will be paid for:

1. **Benefits** for events that are not listed as **covered events** in Section IV - **Covered Events**.
2. **Disability** when a **covered employee's** coverage was not in effect under the **policy**. This includes **disability** either prior to the effective date of coverage or after such coverage ends. This does not include a termination of coverage because the **employee** is not **actively at work** due to **disability** as long as premium is paid. If an employee is no longer **actively at work** due to **disability**, **benefits** for a **period of disability** will not terminate if the **policy** remains in force and premiums are paid for the lesser of:
   a. 3 **months**; or
   b. the **period of disability**.
3. **Disability** when the **covered employee** is not under the **regular care** of a **physician**.
4. **Disability** caused or contributed to by the **covered employee's** commission of or attempt to commit a felony.
5. **Disability** caused or contributed to by the **covered employee** being engaged in an illegal activity.
6. **Disability** caused or contributed to by the **covered employee's** commission of civil or criminal assault or battery.
7. **Disability** while a **covered employee** is on active duty in the Armed Forces including the National Guard.
8. **Disability** related to the **covered employee's** job to the extent it is covered or is required to be covered by **Workers' Compensation**. This exclusion applies to any **disability** that is covered or is required by law or regulation to be covered by **Workers' Compensation**. This exclusion applies if coverage under **Workers' Compensation** is required by law or regulation and was not purchased by the **covered person's employer**. A **covered employee** must submit any potentially work related claims to his **Workers' Compensation** insurer. Coverage is not provided for potentially work related claims that are not submitted to the **Workers' Compensation** insurer.

   If the **covered employee** enters into a settlement giving up his right to recover past or future wage loss under **Workers' Compensation**, **we** will not pay past or future wage loss that is the subject of or related to that settlement. .
9. Coverage under the **policy** will not duplicate coverage provided or required to be purchased or provided under federal, state, or local laws, regulations or programs. **We** will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion applies whether or not the **covered employee** chooses to waive his rights to these programs.
10. **Disability** claims that are submitted more than one year after a **disability** begins.
11. **Disability** caused by or arising out of acts of war, insurrection, rebellion, armed invasion or aggression.
12. **Disability** certified by a **close relative** or member of the **covered employee's** household or legal guardian of the employee who received the service. "Member of the **covered employee's** household" means anyone who lives in the same household or who was claimed as a tax deduction for the year during which the service was provided.
13. **Disability** beginning while held detained or imprisoned in a local, state or federal penal or correctional institution or while in the custody of law-enforcement officials. **Employees** on work release are not considered to be held, detained or imprisoned.
14. **Disability** arising out of, or related to any intentionally self-inflicted bodily injury.

SECTION V - EXCLUSIONS

Words and phrases appearing in **bold** type have special meaning as set forth in Section VI - Definitions.

The following exclusions apply to all coverages described in the **policy**. Coverage is not provided for and no **benefits** will be paid for:

1. **Benefits** for events that are not listed as **covered events** in Section IV - **Covered Events**.
2. **Disability** when a **covered employee's** coverage was not in effect under the **policy**. This includes **disability** either prior to the effective date of coverage or after such coverage ends. This does not include a termination of coverage because the **employee** is not **actively at work** due to **disability** as long as premium is paid. If an employee is no longer **actively at work** due to **disability**, **benefits** for a **period of disability** will not terminate if the **policy** remains in force and premiums are paid for the lesser of:
   a. 3 **months**; or
   b. the **period of disability**.
3. **Disability** when the **covered employee** is not under the **regular care** of a **physician**.
4. **Disability** caused or contributed to by the **covered employee's** commission of or attempt to commit a felony.
5. **Disability** caused or contributed to by the **covered employee** being engaged in an illegal activity.
6. **Disability** caused or contributed to by the **covered employee's** commission of civil or criminal assault or battery.
7. **Disability** while a **covered employee** is on active duty in the Armed Forces including the National Guard.
8. **Disability** related to the **covered employee's** job to the extent it is covered or is required to be covered by **Workers' Compensation**. This exclusion applies to any **disability** that is covered or is required by law or regulation to be covered by **Workers' Compensation**. This exclusion applies if coverage under **Workers' Compensation** is required by law or regulation and was not purchased by the **covered person's employer**. A **covered employee** must submit any potentially work related claims to his **Workers' Compensation** insurer. Coverage is not provided for potentially work related claims that are not submitted to the **Workers' Compensation** insurer.

   If the **covered employee** enters into a settlement giving up his right to recover past or future wage loss under **Workers' Compensation**, **we** will not pay past or future wage loss that is the subject of or related to that settlement. .
9. Coverage under the **policy** will not duplicate coverage provided or required to be purchased or provided under federal, state, or local laws, regulations or programs. **We** will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion applies whether or not the **covered employee** chooses to waive his rights to these programs.
10. **Disability** claims that are submitted more than one year after a **disability** begins.
11. **Disability** caused by or arising out of acts of war, insurrection, rebellion, armed invasion or aggression.
12. **Disability** certified by a **close relative** or member of the **covered employee's** household or **legal guardian** of the employee who received the service. "Member of the **covered employee's** household" means anyone who lives in the same household or who was claimed as a tax deduction for the year during which the service was provided.
13. **Disability** beginning while held detained or imprisoned in a local, state or federal penal or correctional institution or while in the custody of law-enforcement officials. **Employees** on work release are not considered to be held, detained or imprisoned.
14. **Disability** arising out of, or related to any intentionally self-inflicted bodily injury.

Words and phrases appearing in **bold** type in the **policy** have special meaning as set forth below.

1. **Accidental Injury**

   means bodily injury caused by something unforeseen, unexpected, unusual, extraordinary or phenomenal, taking place not according to the usual course of things or events that results in **disability** within 5 **calendar days**.

2. **Active Work / Actively At Work**

   means an **employee** is performing all of the duties of the job with an **employer** for a minimum of 30 hours per **week**. An **employee** will be considered **actively at work** on:

   a. Any scheduled work day he is performing his regular duties for the **employer** at the **employer's** place of business or a location where his **employer** requires him to travel; or

   b. Any day of a paid vacation; or

   c. Any regularly scheduled non-working day, provided that the **employee** was at work on the last regular working day prior to that date.

3. **Authorized representative**

   means the person designated by a **covered employee** to contact us regarding a **grievance**. The designation must be in writing, specifically authorize contact with us regarding a **grievance** and be signed by the **covered employee**.

4. **Beneficiary**

   means the **covered employee's spouse**, mother, father, child or children, brothers or sisters, or executor or administrator of the **covered employee's** estate.

5. **Benefits**

   means the amount payable for **disability** that qualifies for coverage under the **policy**.

6. **Calendar Day**

   means the period starting at 12:01 a.m. Central Standard Time on any day and ending at midnight on that day.

7. **Close Relative**

   means:

   a. **Spouse**;

   b. **Covered employee's** child, brother, sister, or parent; and/or

   c. **Covered employee's spouse's** child, brother, sister or parent.

8. **Covered Employee**

   means an **employee** who is eligible for coverage under the **policy**, has applied for coverage and for whom a premium is paid to **us**.

9. **Covered Event**

   means **disability** caused by an **accidental injury** or an **illness or injury**.

10. **Disabled** or **Disability**

    An **employee** will be considered **disabled** if because of an **illness or injury** or **accidental injury**:

    a. He is unable to perform the basic duties of his occupation; and

    b. He is not performing any work or engaging in any other occupation for wage or profit; and

    c. He is under the **regular care** of his **physician**.

11. **Employee**

means someone who is **actively at work** in an **employer's** business. **Employee** does not include owners, shareholders or officers of the business who are not **actively at work** in the business. The **employee** must be reasonably compensated and his **employer** must report his earnings as required for Social Security. Temporary **employees**, consultants, advisors and other similar individuals do not qualify as **employees**.

12. **Employer**

means an **employer** who, in order to provide group health coverage to eligible **employees**, purchased the **policy** or participates in a multiple employer trust that purchased the **policy**.

13. **Grievance**

means any dissatisfaction with the administration or claims practices of or provision of service by **us** which is expressed in writing by or on behalf of a **covered employee**.

14. **Illness or Injury**

means any bodily disorder, bodily injury, disease or **mental illness**. This includes pregnancy.

15. **Maximum period of benefits**

means the longest time **benefits** will be paid for any one **period of disability**. The **maximum period of benefits** is shown in the **schedule**.

16. **Mental Illness**

means a condition that manifests symptoms for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause.

In determining whether or not a particular condition is a **mental illness**, **we** may refer to the edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association that is most current at the time the **mental illness** is diagnosed.

17. **Month**

means the period starting at 12:01 a.m. Central Standard Time on the 1st day of a given calendar **month** and ending at midnight on the last day of the calendar **month**.

18. **Period of Disability**

means the time a **covered employee** is **disabled.** If a **covered person** returns to work after a **period of disability** but becomes **disabled** again the second **period of disability** will be considered a continuation of the original **period of disability** for purposes of applying the **benefit** limits in the following situations:

a. if the **disability** is due to or related to same **illness or injury** or **accidental injury** as the original **disability** and the **covered employee** was **actively at work** for less than 2 months between periods of **disability**;

b. if the **disability** is not due to or related to the same **illness or injury** or **accidental injury** as the original **disability** and the **covered employee** was **actively at work** for less than 1 **calendar day** between **periods of disability**.

19. **Physician**

means a licensed medical doctor. For **mental illness** services, **physician** includes a licensed psychologist. When **we** are required by law to cover the services of any other licensed medical professional under the **policy**, a **physician** also includes such other licensed medical professional who:

a. Is acting within the lawful scope of his license; and

b. performing a service that is covered by the **policy**.

20. **Policy**

means policy forms, amendments and riders that constitute the agreement regarding the **benefits**, exclusions and other conditions.

21. **Proof of Good Health**

means satisfactory proof, as determined by **us**, that the **employee** is acceptable for coverage.

22. **Regular Care**

means a planned program of observation and treatment of the **illness or injury** or **accidental injury** causing **disability** carried out by a **physician** according to current standards of medical practice.

23. **Schedule**

means the **Schedule** of Benefits attached to the **policy**.

24. **Spouse**

means a person of opposite gender at birth, legally married to a **covered employee**.

25. **Waiting Period**

means the period of time that must pass before coverage begins for an eligible **employee** who enrolls for the **policy**.

26. **Week** or **Weekly**

means the 7-day period from Sunday through Saturday.

27. **Weekly Benefit**

means the amount payable as **benefits** for each **week** of **disability**. The amount is calculated by multiplying the **weekly wage** by the percentage of the **weekly wage** payable as **benefits** shown in the **schedule** minus deductions required by state or federal law.

28. **Weekly Wage**

means the amount of wages or salary paid by the **employer** to the **covered employee** each **week**. **Weekly wage** does not include bonuses, dividends, or incentive compensation.

a. If the **covered employee** is paid on an hourly basis, the **weekly wage** is his base hourly wage multiplied by the number of hours he is scheduled to work each **week**.

b. If the **covered employee** is paid a salary, the **weekly wage** is his current annual salary divided by 52.

c. If the **covered employee** is paid solely by commission, the **weekly wage** is the lesser of any guaranteed minimum **weekly** commission or the average commission paid to him in the last 12 **weeks**.

29. **Workers' Compensation**

means insurance **benefits** mandated under state **Workers' Compensation** laws.

SECTION IX - **GRIEVANCE** AND APPEAL PROCEDURES

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions.

1. SUBMISSION OF **GRIEVANCES**

   Initially **grievances** should be submitted to our [Medical Benefits & Services Appeals Department] at:

   [Medical Benefits & Services Appeals]
   [Federated Mutual Insurance Company]
   [P.O. Box 328]
   [Owatonna, MN 55060]
   [Fax: 507-446-4723]
   [E-mail: healthappeals@fedins.com]

   After that review is completed, a second level **grievance** can be submitted to **our**.[Medical Benefits & Services Appeals]. A **covered employee** can also contact the local U.S. Department of Labor Office or insurance regulator in their state to submit a **grievance** or complaint.

   A **covered employee** or **beneficiary** can appoint an **authorized representative** to act on his behalf in pursuing a **grievance**. The appointment of an **authorized representative** for handling **grievances** must be in writing and signed by the **covered employee** or **beneficiary**.

   Initial **grievances** must be submitted within 180 calendar days of the event giving rise to the **grievance**. The event giving rise to the **grievance** can be a notice of **benefit** determination, a notice of rescission of coverage, an administrative action by **us** or the provision of another service by **us**. For a **grievance** related to a notice of **benefit** determination or a notice of rescission of coverage, the date of the event is printed on the notice. For a **grievance** related to an administrative action by **us**, the date of the event is the date **we** took the administration action. For a **grievance** related to the provision of another service by **us**, the date of the event is the date **we** provided the service.

   Second level **grievances** must be submitted within 60 calendar days of the date printed on the written notice of the initial **grievance** decision.

2. INITIAL **GRIEVANCE** PROCEDURE

   When an initial **grievance** is received by our [Medical Benefits & Services Appeals Department], the following procedure will be used.

   a. Written acknowledgment of the **grievance** will be sent to the **covered employee**, **beneficiary** and/or the **authorized representative** within 3 working days. This shall include the name, address and phone number of the person handling the **grievance** and information on how to submit written material.

   b. The person reviewing the **grievance** will not be the same person who initially reviewed the claim. .

   c. An investigation will be completed and a decision made within 30 calendar days.

   d. Written notice of the decision will be sent to the **covered employee** and/or the **authorized representative**. That notice shall include:

      i. The specific reason for **our** decision.

      ii. The specific policy provisions applicable to the **grievance**.

      iii. Any internal guidelines used in making the decision.

      iv. Information on how to file a second level **grievance** and the right to sue after internal **grievance** procedures are completed by **us**.

      v. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

      vi. In states where the **covered employee** has a right to review by the state regulatory agency, information on how to obtain that review.

3. SECOND LEVEL **GRIEVANCE** PROCEDURE

A second level **grievance** is initiated by sending a request for review to:

[Medical Benefits & Services Appeals]
[Federated Mutual Insurance Company]
[P.O. Box 328]
[Owatonna, MN 55060]
[Fax: 507-446-4723]
[E-mail: healthappeals@fedins.com]

Or by calling [507-455-5200] or toll free [800-533-0472] and asking for the [Medical Benefits & Services Appeals Department].

Our [Medical Benefits & Services Appeals Department] will complete this review.

When a second level **grievance** is received by **our** Medical Benefits & Services Appeals Department], the following procedure will be used.

a. Written acknowledgment of the **grievance** will be sent to the **covered employee** and/or the **authorized representative** within 3 working days. This shall include the name, address and phone number of the person handling the **grievance** and information on how to submit written material.

b. The person reviewing the **grievance** will not be the same person who initially reviewed the claim.

c. An investigation will be completed and a decision made within 30 calendar days.

d. Written notice of the decision will be sent to the **covered employee** and/or the **authorized representative**. That notice shall include:

   i. The specific reason for **our** decision.

   ii. The specific policy provisions applicable to the **grievance**.

   iii. Any internal guidelines used in making the decision.

   iv. Information on how to obtain copies of documents **we** have on the **grievance**.

   v. Information on the right to sue after internal grievance procedures are completed by **us**.

   vi. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

   vii. In states where the **covered employee** has a right to review by the state regulatory agency, information on how to obtain that review.

4. RECORDKEEPING

We will maintain a record of all **grievances** filed and their resolution. The record will include the name of the **covered employee**, date of the **grievance**, nature of the **grievance**, date of response/resolution and summary of the resolution. Copies of all **grievances**, investigative material and response letters will be kept with the **grievance** record. The **grievance** record will be maintained in the claims office for a minimum of 5 years.

Periodically, **we** will review the **grievance** record. This review will include analysis of the appropriateness of responses.